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COMMITTEE ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS

Ninth session

SUMMARY RECORD OF THE 41st MEETING

Held at the Palais des Nations, Geneva,
on Monday, 6 December 1993, at 10 a.m.

Chairperson: Mr. ALSTON

later: Mr. ALVAREZ VITA

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General discussion on the right to health (minimum core content and non-discrimination dimensions) as recognized in article 12 of the Covenant

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The meeting was called to order at 10.15 a.m.

GENERAL DISCUSSION ON THE RIGHT TO HEALTH (MINIMUM CORE CONTENT AND NON-DISCRIMINATION DIMENSIONS) AS RECOGNIZED IN ARTICLE 12 OF THE COVENANT (agenda item 5) (E/C.12/1993/WP.17-25)

1. The CHAIRPERSON said that he was pleased to open the day of general discussion on the right to health, with particular emphasis on the principle of non-discrimination and the minimum core content that constituted a floor below which conditions should not be permitted to fall in any State party.

2. The purpose of days of general discussion was to shed light on the content of various rights set forth in the Covenant, with the help of outside experts and non-governmental organizations (NGOs). The present discussion would serve to provide material for a general comment on the right to health on which the Committee could begin work at its next session. Economic, social and cultural rights had been called into question by the trend towards free market economics and the pressures to trim social budgets and to permit economic factors to become dominant. The human rights community now had a duty to show why certain economic, social and cultural rights should be considered immune from economic pressures and to respond to critics who maintained that the right to health was valid only in so far as it contributed to economic progress.

3. To simplify the discussion, he had divided the proceedings into six topics: (1) overview of the issues, (2) defining health for the purposes of article 11, (3) the significance of recognizing health as a human right, (4) non-discrimination, (5) the concept of a "core content", and (6) monitoring a right to health: national and international dimensions. Members of the Committee were invited to intervene at any point in order to ask questions or to challenge the comments made by speakers. He invited the Committee to consider the first topic.

4. Mr. ALVAREZ VITA, introducing document E/C.12/1993/WP.22, said that the text concentrated on two aspects of a very broad field - the consequences of the principle of non-discrimination and the minimum core content below which conditions should not be permitted to fall. The limits of the working paper had been established as a result of a meeting which the Pre-Sessional Working Group had held with Miss Geneviève Pinet, Senior Legal Officer, Office of the Legal Counsel, World Health Organization. It should be borne in mind that although there was an abundant bibliography on health, very little of it related to health as a human right. As with all other human rights, the approach to the right to health had to be multidisciplinary. His working paper was, of course, only a starting point that required further analysis of the changing circumstances in the world, in which the only constant feature was the inherent dignity of all persons.

5. In chapter I the introduction to the working paper contained a brief analysis of the legal nature of the right to health and of economic, social and cultural rights in general and compared those rights with civil and political rights, the former being less precise and less justiciable than the latter. The Committee was in fact preparing an optional protocol establishing a list of justiciable economic, social and cultural rights.

6. Chapter II dealt with the dual responsibility of States, international and domestic, with regard to human rights instruments. In that connection he drew particular attention to paragraphs 5-13. Chapter III was concerned with international custom and with the general principles of law relating to the right to health, and Chapter IV with the basic concepts of the right to health and their legal aspects. He stressed the comments by Ruth Roemer and Walter T. von Wartburg reproduced in paragraph 23.

7. Chapter V reviewed guarantees with regard to the right to health, dealing in particular with the obligation of the State to refrain from acts that could endanger people's health, especially those mentioned in paragraph 25, with the obligation of the State to take action, especially the measures mentioned in paragraph 30, and with the justiciability of the right to health. Chapter VI was concerned with the egalitarian aspect of the right to health. He drew particular attention to paragraphs 34 and 35. Chapter VII dealt with discriminatory practices in relation to the right to health. He highlighted paragraphs 37, 40 and 42, as well as paragraph 43 on discrimination against women and the following passages on female circumcision, the preference for male children, other forms of discrimination, discrimination against indigenous minorities and groups, violence against ethnic groups, the situation of the disabled, and the effects of international markets on the right to health.

8. Chapter VIII, entitled "The right to health in the framework of international human rights law", dealt with the genesis of the international system, international cooperation and the role of the United Nations. He drew attention to the contents of paragraphs 49 and 57 and of various Articles of the Charter of the United Nations, article 28 of the Universal Declaration of Human Rights, article 2 of the International Covenant on Economic, Social and Cultural Rights, and the Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights. Chapter VIII was also concerned with the obligation to respect the right of other States to shared resources, the right to avail oneself of science and technology, the obligation to respect access by all to world scientific progress, and the duty to cooperate and form associations to secure protection from exploitation.

9. Chapter IX reviewed the provisions of the International Bill of Human Rights in so far as they affected the right to health. In that connection it should be borne in mind that the rules for the interpretation of treaties took into account not only the meanings of the words used at the time when the treaty had been drafted, but also the meanings that they had at the present time.

10. Chapter X was concerned with other international instruments on human rights, and chapter XI with the American, African and European regional systems. Chapter XII dealt with specialized agencies and the right to health, with particular reference to the criteria established by WHO. Chapter XIII was concerned with the Commission on Human Rights, international humanitarian law and the right to health and included passages on experiments with human beings, the clinical testing of medicines, the use of chemical additives

in foods and drinking water, the deterioration of the environment, pharmaceuticals, and the right to make use of scientific and technological progress.

11. Chapter XIV dealt with the implication of enjoyment of the right to health in human development, covering such matters as population growth and ageing, rapid urbanization, inadequate health services, limitations on social security, traditional medicine, and the challenges posed, including those posed in respect of related human rights like the right to food and the right to housing.

12. Chapter XV dealt with the very important matter of compliance with economic, social and cultural rights and their minimum core content. Any minimum limit established could not, of course, be used to call into question the unity of mankind. Paragraph 140 of the working paper contained 21 conclusions.

13. Since finishing the working paper, he had received a number of communications from NGOs and individuals which would also need to be considered during the discussion.

14. Dr. MANN (Harvard School of Public Health) said that the recent rediscovery of inextricable linkages between human rights and health was one of the great advances in the history of health and society. The global AIDS pandemic, had taught a fundamental lesson: the major causes of preventable illness, disability and premature death lay as much in societal discrimination, inequity and injustice as in viruses or parasites.

15. The connection between health and human rights was implicit in the World Health Organization's definition of health as a state of complete physical, mental and social well-being. Health encompassed far more than biomedical technology and care; it embraced and depended upon the cultural, economic, civil, political and social dimension of life. In addition, public health had been defined as the task of ensuring the conditions in which people could be healthy. It was clear that certain societal conditions promoted health, while others were detrimental to it.

16. Three dimensions to the complex relationship between health and human rights could be proposed. The first considered the manner in which health policies could violate human rights. Key international human rights documents recognized that public health was an acceptable reason for derogating from human rights norms. That privileged status of public health in relationship to human rights derived from the history of traditional communicable disease control. However, modern public health was much more concerned with behaviour - individual and collective - in respect of, for example, tobacco and alcohol and other substance use and abuse, injuries, cancer, child abuse, cardiovascular disease or unwanted pregnancies. An analysis of existing programmes frequently uncovered a lack of respect for human rights, and particularly of hidden and unrecognized discrimination in the design and implementation of programmes. Health officials bore special responsibility

for ensuring that any human rights violations on grounds of health were strictly necessary and were carried out in the least restrictive manner possible, after careful consideration of other less burdensome alternatives.

17. Secondly, it was obvious that human rights violations had health impacts. Clearly, the victims of torture or imprisonment suffered severe health effects, as did civilians whose rights were violated during conflicts. Yet violations of other rights might also have substantial health effects in hitherto invisible areas. For example, it was not known how many preventable cancers were attributable to the marketing of tobacco in the third world while violating the right to information about its consequences, how many women and children had died as a result of violation of the right to education or how much preventable morbidity and premature mortality was attributable to violations of the right to just and favourable conditions of work. Violations of human rights caused great harm to health, not only in an abstract manner, but in specific and measurable ways.

18. The AIDS pandemic, and the experience of AIDS prevention and care suggested a third and more profound connection between respect for human rights and health: respect for and protection of rights and dignity was an essential condition for people to be healthy and for the promotion of health status.

19. The critical question was what, if anything, was wrong with the current analysis of those conditions in which people could be healthy.

20. Although socio-economic status had traditionally been identified as the single most powerful correlate of health status, observations of the differential health status among different groups suggested that income level and social class were only partial explanations of health status. For example, societal vulnerability to the spread of AIDS had been found to be strongly associated with the scope, intensity and nature of discrimination practised within each society. For example, monogamous and married women in many parts of the world were becoming HIV-infected solely because of their inability to control their husbands' sexual behaviour. A broader analysis of women's rights and health showed clearly that male domination of societies was a threat to public health. It was necessary, actively to deconstruct the current conceptual explanation of poor health, disability and premature death, which generally went no further than poverty or socio-economic factors. A careful analysis of the major causes of preventable illness, disability and premature death showed that like HIV/AIDS, they were inextricably linked with societal discrimination and lack of respect for fundamental human rights and dignity. That approach also suggested that human rights might provide a more useful framework for identifying the diverse dimensions of life which are linked with or even determinant of health status. Thus, the thinking that led to the Universal Declaration of Human Rights and its list of fundamental and inalienable rights might provide a useful entry point for consideration of the conditions in which people could be healthy. An important recent development

in that respect had been the identification, in the World Bank's World Development Report 1993, of the education of women as the single most important means of improving health in developing countries.

21. The exploration of the full dimensions of the relationship between rights status and health status had only just begun. To illustrate the potential of that approach, one might consider the concept of dignity, of which there was no adequate definition or classification to enable its relationship to health to be examined. Nevertheless, when society undermined or diminished personal and collective dignity, health could be seriously affected. Most people, regardless of their prestige and power, had experienced some situation in which they felt their dignity was impugned. Such a situation was associated with anger, frustration and tension. The health consequences stemming from sustained or repeated injury to dignity could be enormous and had yet to be measured. Moreover, another form of violation of dignity might involve invasion of bodily integrity, and another could result from being ignored and denied recognition as a person.

22. The knowledge and experience of health experts could also point towards human rights problems by establishing connections between events, such as illness, disability and death, which had traditionally been experienced as individual tragedies, and the societal and governmental choices, inequities and injustice from which they were indissociable. Epidemiology not only identified clusters of illness, disability or premature death; it was also uncovering presumptive evidence of a system which permitted or even created those conditions in which some were sick, handicapped or dead, while others were healthy and alive. Part of the responsibility of health workers was to identify and understand the inequalities, injustices and violations of human rights which lay beneath each epidemiological cluster.

23. The right to health itself was enshrined in several fundamental documents, most particularly the International Covenant on Economic, Social and Cultural Rights and the preamble to the Constitution of the World Health Organization. However, the right to health still had to be adequately defined, more broadly conceptualized and then promoted and protected through the United Nations system. It was worth reiterating that health was a right which was highly dependent on the realization of all other rights.

24. There was another paradox in the gap between the perceived importance of health for all people and the fragmentary and modest claims and expression of that aspiration in political terms. Nowhere was health understood and articulated in the large vision of physical, mental and social well-being, nor was there widespread realization of the conditions which people needed in order to be healthy. The AIDS epidemic had catalyzed the discovery or perhaps the modern rediscovery of the fundamental connection between health and human rights. Neglect and abuse of human rights and dignity were powerful "risk factors" which operated at a global level to produce sickness and death. Any discussion of health which was limited to health care alone could not be sufficient. States would only be successful in preventing AIDS, caring for

all who were infected and ill and protecting the health of all to the extent that they could reduce discrimination and promote respect for rights and dignity.

25. Health workers had been slow to recognize and respond to the central importance of rights and dignity, but were now ready to join in a common struggle to preserve and protect the future of mankind. The health community welcomed the opportunity to provide input to the deliberations of the Committee on Economic, Social and Cultural Rights on the subject of health and human rights, and would welcome requests to States parties that reporting under article 12 of the Covenant should include both a broad assessment of rights status and of the indicators suggested by WHO in line with its Health for all strategy. In reviewing reports by States parties, the Committee might consider the status of AIDS-related policies and programmes as an indicator of the status of the broad range of issues encompassed within the right to health.

26. Mrs. LEARY (State University of New York) said that she would focus on the relation between economic resources and the implementation of the right to health. Under article 2, paragraph 1 of the Covenant, each State party undertook to take steps for the progressive realization of the rights enshrined in the Covenant "to the maximum of its available resources". Although the importance of economic and social development to health was evident, it was too rarely emphasized that there were many important measures to protect and promote the right to health which were not expensive, which were cost-effective and which could and should be adopted by all countries, regardless of their level of economic development.

27. Mr. Alvarez Vita had already referred to the Limburg Principles on the Implementation of the Covenant on Economic, Social and Cultural Rights, which specified that States parties were obligated, regardless of their level of economic development, to ensure respect for minimum subsistence rights for all. Given the shortage of resources in developing countries and the increasing cost of health care in high-income countries, attention should be focused on the most effective of resources to increase the level of health in both poor and rich countries.

28. While she agreed that the right to health was important, not simply because it contributed to economic development, but because it was a fundamental human right, she considered that the importance of the right to health in economic development might be emphasized by the Committee in its dialogue with developing countries. In the 1993 World Development Report, Investing in Health, the World Bank had noted that health contributed to economic growth in four ways: by reducing production losses through illness, by permitting the use of hitherto inaccessible natural resources, by increasing school enrolment and by releasing for alternative uses resources that would otherwise have been spent on treating illness.

29. While the promotion of health contributed to development, there was no automatic link between resources and health status. Although the health of citizens was generally far worse in low-income or middle-income countries

than in high-income countries, some low- and middle-income countries had considerably better health statistics than other developing countries. For example, citizens of Sri Lanka and China had a life expectancy at birth comparable to that of many high-income countries. In turn, among the developed countries the United States had an infant mortality rate of 9 per 1,000 live births, while Japan and Switzerland attained a level of 5 per 1,000. Examination of the link between economic resources and health status suggested that it was not economic development alone that caused an improvement in health status, but rather the adoption of specific national policies regarding health and related issues. As was pointed out in the 1990 Human Development Report of UNDP, there was no automatic link between the level of per capita income in a country and the level of its human development.

30. Referring to the most cost-effective means of promoting health, she said that obstacles to improving health within countries were often due to misallocation of existing resources, inequity in health care and inefficiency. In its global strategy "Health for all by the year 2000", the World Health Organization had emphasized preventive health measures rather than curative measures, and the adoption of primary health care as the basic reorientation of health policy to achieve the most cost-effective improvement of health status. The Committee on Economic, Social and Cultural Rights had produced valuable guidelines in relation to article 12 of the Covenant, although they could be improved by identifying specific points that were important in order to protect the right to health.

31. Turning to specific measures, she noted that breast-feeding had been widely recognized as an unequalled way of providing ideal food for the healthy growth and development of infants. WHO had also developed and promoted the important International Code of Marketing of Breast-milk Substitutes. The Committee might inquire of a reporting State whether it was implementing WHO's 10 steps to successful breast-feeding. Because of the emphasis on developing countries during the adoption of the Marketing Code, it was sometimes overlooked that breast-feeding was an important issue in high-income countries. A 1991 study in the United States had noted a dangerous decline in breast-feeding in recent years. The decline was particularly notable among low-income young and minority women, and the role of educational factors in that decline might be considered a form of discrimination.

32. There was overwhelming evidence that tobacco smoking was the major cause of lung cancer, and an important cause of other cancers. States which had undertaken a commitment to the right to health should adopt a series of measures to discourage the use of tobacco, such as advertising restrictions or taxes. However, some high-income countries had adopted such measures in their own countries, but still encouraged the export of tobacco to other countries, including developing countries, through export subsidies and other export promotion measures. Such policies were an egregious violation of the right to health.

33. Although the detrimental effects of alcohol on health were not as widely recognized as those of tobacco, studies had indicated that increased alcohol consumption entailed a rise in the development of certain types of cancer. Educational programmes, limits on advertising, warnings on alcohol containers and limits on the age at which alcohol could be purchased were some of the measures which should be taken to discourage alcohol abuse.

34. The purchase of prescription drugs was an important element in the cost of health care. The importance of a rational national drug policy had been emphasized by WHO, which had pointed out that a national drug policy should include legislation to ensure the safety, responsible marketing, rational selection and use of drugs entering the national market. Although WHO's Essential Drug Programme had identified a limited number of drugs as essential for health, the Programme had encountered substantial opposition from pharmaceutical companies, and, moreover, some countries exported drugs which had proved ineffective or even unacceptable on their home markets.

35. Finally, she underscored the importance of primary health care as the basis of a national health care policy. A programme of primary health care, incorporating an emphasis on health education, the promotion of maternal and child health care, immunization and generally preventive rather than curative measures had been developed by WHO. The programme emphasized maximum community and individual self-reliance and the formulation of national health policies. Official adoption of the programme by a country would constitute an important step to promoting the realization of the right to health.

36. Mr. GRISSA, while expressing appreciation of the statements contributed by the two previous speakers, said that he regretted the tendency to emphasize the right to health and to overlook the responsibility of individuals for their own and their children's health. AIDS, alcoholism and tobacco-induced diseases were the direct results of irresponsible behaviour. People certainly had a right to health, but did they not also have the right to drink, to smoke and to engage in sexual intercourse? The point at issue was surely to promote a greater sense of responsibility.

37. Mrs. JIMÉNEZ BUTRAGUEÑO also thanked Dr. Mann and Mrs. Leary for their statements. In her view, two of the points made deserved particular emphasis: first, the enhanced threat to women's health in male-dominated societies and, second, the link between social and economic factors on the one hand and health on the other.

38. Mr. SIMMA said that he had some doubts as to the possibility of directly correlating a society's performance in terms of human rights with its performance in terms of health. Could such linkage be established in the case of a country like, say, Singapore, whose concept of human rights was very different from the highly individualized western model? As for alcoholism and the ill-effects of tobacco consumption, he entirely agreed that drinking and smoking should be discouraged, but could not help feeling that to impose bans would create a conflict between different human rights and freedoms. Should pornography, too, be banned as a threat to health?

39. The CHAIRPERSON invited the Committee to proceed to the consideration of the second topic, namely, defining health for the purposes of article 11.

40. Dr. MARTIN (Cantonal Doctor of Vaud) introduced the working paper contained in document E/C.12/1993/WP.18.

41. Ms. SIMS (Galilee Society for Health Research and Services) read out the working paper contained in document E/C.12/1993/WP.23, omitting, however, the recommendations put forward in the penultimate paragraph of the paper.

42. Mr. TEXIER, drawing attention to the point made in paragraph 15 of document E/C.12/1993/WP.18 about the right to health was in fact a "derived" right, stressed the importance, if not of arriving at a precise definition of health for the purposes of article 11, at least of attempting to work out some clear-cut ideas on the subject. Referring to the suggestion contained in document E/C.12/1993/WP.23 that the Committee should conduct periodic independent investigations into the accuracy of reporting by States on their activities in the public health field, including the promotion of a safe and hygienic environment for all sectors of their population, he said that obtaining government authorization for investigations of that kind was an extremely difficult process. While he personally approved of the idea, he felt bound to point out that the Committee was still awaiting a favourable response from two Governments which it had approached in connection with proposed field investigations on the subject of housing and, in particular, of evictions.

43. Mr. GRISSA said that, as well as bearing responsibility for environmental threats to their own populations, industrialized countries should also be held responsible for the adverse impact of transfers of industrial wastes to poorer countries. In some cases bribery was used to induce countries to accept the dumping of such wastes. A similar problem was that of acid rain spreading from Western Europe to, say, Poland, or from the United States to Canada. In focusing its attention on issues of that kind the Committee would be on more solid ground than in applying human rights standards to cigarette consumption.

44. The CHAIRPERSON invited the Committee to consider the third topic, namely, the significance of recognizing health as a human right.

45. Dr. FISHER (Commonwealth Medical Association), also representing the British Medical Association (BMA), said that recognition of human rights in a society should be a marker for the health of that society. Doctors and health care workers were among the first to become aware of violations of human rights such as the right of every individual to be born as healthy as possible. The exercise of that right obviously presupposed the existence of sound programmes of anti-natal, intra-partum and post-partum care, as well as suitable employment rules and financial support to mothers wishing to breast-feed their babies. All women, including the very young and the unmarried, should have access to information on family planning services and on possibilities of safe termination of pregnancy within the law. Their ability to benefit from such information was, of course, predicated upon an adequate level of literacy.

46. Independence of the medical profession was essential if doctors were to be able to alert Governments and the society at large to human rights violations in the field of health. Drawing attention to a recent BMA publication entitled Medicine Betrayed, which dealt with the involvement of

medical practitioners in human rights abuses and torture world wide, she said that a general point that emerged from the publication was that doctors and health care workers had to be made aware of the fact that recognition of the dignity and worth of the individual was fundamental to health. Children, in particular, had a right to adequate protection against abuse of all kinds and to treatment of damage sustained as a result of abuse. Although it was now widely recognized that sexual abuse in childhood was a major determining factor in the admission of women to psychiatric hospitals, such experiences were rarely reflected in the medical histories of women patients.

47. While entirely agreeing that individuals ought to take responsibility for their own health, she remarked that they could hardly do so unless provided with elementary information. People working for tobacco companies in the third world were almost certainly not aware of the catastrophic effects of smoking, including passive smoking, upon their children, both born and unborn.

48. As well as preserving their own independence, national medical associations should encourage their Governments to view health as an investment in the country's economic future rather than simply as an item of expenditure. They should also insist that training in medical ethics should be a core part of the curriculum for doctors and health care professionals.

49. It was also clear that investment by United Nations and other international agencies in national programmes should be linked to the need for measurable improvements in health care and other economic indicators. And it was important for national medical associations to be as sure as possible that the effectiveness of all health intervention strategies and programmes could be monitored; that aspect should become a part of professional training. The issue was of great importance in developing and developed countries alike.

50. The Commonwealth Medical Association believed that medical associations everywhere had an important role to play, and that WHO could do much to enhance support and recognition in that regard, with a view to promoting a greater understanding of health care at the international level.

51. She added that a number of countries had already expressed interest in the publication referred to, which was being translated into several other languages.

52. The CHAIRPERSON said he felt sure that a copy of the text would be of interest to the Committee. The latter would welcome information from non-governmental and other organizations, at any time, with regard to health issues which it was felt the Committee could raise in considering the reports submitted by States parties. In that connection, he would make available, to anyone interested, a list of States parties whose reports were to be considered by the Committee at its two sessions of 1994.

53. Mrs. SIMONOTTI (International Union for Health Promotion and Education) said that her organization attached great interest to the document prepared by Mr. Alvárez Vita on the right to health (E/C.12/1993/WP.22), particularly with regard to the concept of a "floor" below which States parties should not allow conditions to fall. Although some 45 years had elapsed since the adoption of the Universal Declaration of Human Rights, its provisions were often ignored

by States; in particular, some States parties to the International Covenant on Economic, Social and Cultural Rights failed to live up to the provisions of its article 12.

54. It was time to focus less on the prevention of illness and more on the right to health. To give effect to the latter meant the development of health education, and of preventive measures, involving an awareness of the ramifications in regard to all aspects of basic human rights and of the way in which the right to health could be adversely affected by factors such as poverty, poor housing, lack of education, environmental problems and denial of the right to work, as well as by discrimination in regard to women, children and minorities. Likewise, the right to peace and development in the context of national and international solidarity had to be promoted. Denial or restriction of the exercise of any human rights, anywhere, added to the detriment of human rights everywhere. Such matters should not only be deliberated in expert forums such as the Committee but should be broadly publicized, inter alia, through more widespread education about the links between health and human rights in general.

55. With regard to the right to health, there could be no ignoring the fact that, in the current highly complex climate, a number of countries which had already achieved high standards in the promotion and protection of human rights, especially in the right to health, were regressing - not to mention the gross violations of human rights stemming from conflicts in many regions. The United Nations could assume a more determinant role in promoting universal awareness of the interrelationship of all human rights and the importance of upholding them. The Declaration of Alma-Ata of September 1978 had reaffirmed that health was a state of physical, mental and social well-being, and not merely the absence of disease or infirmity, and was a fundamental human right. Therefore, it was up to States parties to safeguard and promote the right to health for all their citizens, by measures including education, professional training and prevention.

56. The CHAIRPERSON drew attention to document E/C.12/1993/WP.17 in regard to the previous speaker's statement.

57. Mr. LECKIE (Habitat International Coalition) said that the importance of the right to health and of the indispensable work the Committee should carry out in that regard could be encapsulated in four words: "the poor die young". Poverty, and the attendant poor living conditions, led to frequent ill-health and early death. Certain groups such as migrant workers, refugees, asylum-seekers, ethnic minorities and people subjected to military or colonial occupation often had poorer health than the population at large. One sphere in which the link with health was abundantly clear was that of housing. For over 1 billion persons throughout the industrialized and developing world, housing conditions often heightened rather than prevented health problems; WHO had stated that housing was the environmental factor most frequently associated with disease, and that inadequate housing was invariably associated with higher mortality and morbidity rates; and it had stated its view, in the document Shelter and Health, with regard to the health protection that housing should provide. Three universally valid points could be made, in that regard, concerning the low-income majority in all cities of the developing world.

58. Firstly, their accommodation gave inadequate protection from health risks; amenities which formed part of the right to adequate housing, such as access to drinking water, drainage, sewage disposal, garbage removal, electricity, heating (if necessary) and emergency services had a direct bearing on health. Secondly, low-income groups had little chance of obtaining better places to live, since they lacked the funds to do so. Thirdly, the overwhelming prevalence of insecure housing tenure discouraged such groups from making even small investments in improvements which might prevent threats to health.

59. Although States had long recognized those factors, they had failed to undertake the requisite remedies. Instead, as the trend towards privatization grew, the problems of homelessness and accompanying poor health continued to grow, as Governments increasingly left social care to the whims of the market. Even where Governments had shown some conscientiousness in the provision of housing, many government housing schemes had accentuated physical and mental health problems rather than preventing them. They had likewise failed to prevent discrimination in housing; HIV/AIDS sufferers, for example, could face eviction and had few chances to obtain specifically designed dwellings. Recent cases of Government neglect had been seen in France, Germany and Russia, where some homeless persons had frozen to death.

60. Five key principles could be identified with regard to the basic minimum legal obligations, below which no State should be allowed to go, in regard to health and housing. The first was in equality of treatment, non-discrimination and full access to the rights set forth in the Covenant, irrespective of health status, including the duty to ensure privacy of medical records. The second was the initiating of preventive measures, including the health component of housing and the associated services. The third was the granting of legal security of tenure. The fourth was a demonstration, to the Committee, that the maximum available resources had been devoted to improving health through more appropriate housing laws and policies. The fifth was to ensure that otherwise progressive moves, such as the de-institutionalization of the mentally disabled, did not inevitably result in the non-enjoyment of rights such as the right to housing; States must not be allowed to undertake generally favourable measures if the latter led to growing infringements of economic, social and cultural rights.

61. Recent developments in the medical and health-related spheres, although ostensibly for positive purposes, could easily be manipulated for highly negative ends. Human rights bodies such as the Committee must therefore carefully monitor developments relating to a number of issues. The first was the maintenance of confidentiality of health records, in view of growing computer capacities and increasing difficulties in protecting data and thus the right to privacy. Secondly, gene-mapping could be a potential threat to human rights; an example was the dubious "discovery" of a gene allegedly responsible for homelessness. Thirdly, the day was not distant when DNA tests could be carried out as a means of quasi-determining an individual's likely future health status; availability of such information to insurance companies, employers and public authorities would pose an obvious threat to human rights.

62. The Committee on Economic, Social and Cultural Rights was viewed by increasing numbers of the world's poorest as their hope for justice. The members of that unique, independent body should never forget that, in many respects, it was the last resort for people with no access to real socio-economic justice in their own countries.

63. Mr. Alvarez Vita took the Chair.

64. Dr. FLACHE (Chairman, WHO Working Group on Human Rights) said that he shared most of the views expressed by the previous speakers, and looked forward to an exchange of views following the current general discussion. The interest of WHO in human rights was not as long-standing as might be thought, since it had focused, until the late 1970s, chiefly on public health activities. But the rapid evolution in economic and political systems, and in environmental questions, required WHO to review its activities periodically and make changes accordingly. One major step in that regard had been the adoption, at the 1977 World Health Assembly, of the principle of Health for All. That goal remained valid but needed to be given greater effect by means of international and domestic legislation and strategies, including contributions not only by ministries of health but by other ministries such as agriculture and social welfare.

65. An important part of the broad conceptual framework was the need for action to prevent discrimination against underprivileged groups and other vulnerable sectors of society, pursuant to the preamble to the Constitution of WHO, which stated that the enjoyment of the highest attainable standard of health was one of the fundamental rights of every human being without distinction of race, religion, political belief and economic and social condition.

66. The precarious health situation of the world's most vulnerable groups, the root causes of vulnerability, and the importance of their health status as an essential indicator of development, were reflected in a WHO publication Health dimension of economic reform, prepared for the International Forum on Health held at Accra in December 1971. The Accra initiative had, inter alia, stressed that the health status of the most vulnerable groups could be achieved simultaneously with macroeconomic policy measures, even in situations of economic adjustment. As a result of discussion in the World Health Assembly on the outcome of the Accra meeting, it had been decided to establish a multidisciplinary task force, composed of eminent experts, which would meet in March 1994, with the task of identifying and examining the most pressing current health issues and the groups most affected, with a view to advocating guidelines for future policies and programmes. Its terms of reference included the preparation, in consultation with all interested parties, of recommendations on the protection of health as a basic human right.

67. Other important publications produced or sponsored by WHO included a report on women's health and human rights, which had been widely circulated and well received at the World Conference on Human Rights, and a two-volume work, published in 1989 under the auspices of the Pan American Health Organization, on the right to health in the Americas. The conviction of the right to health as a human right entitled to domestic and international legal recognition was a cornerstone of WHO's approach. An example of the latter was

the development of a coherent monitoring system in the context of the implementation of strategies for Health for All. He had available for study a book on agreed indicators for monitoring, and norms for determining the "floor" below which a violation of the right to health would be deemed to exist. Another instance was the recent conference in Ottawa, under the auspices of the World Bank, the International Development Research Centre of Canada and WHO, on future partnership for the acceleration of health development.

68. Lack of time prevented him from giving further details of WHO's activities, but he remained at the disposal of the Committee and the other bodies represented at the current meeting, and would endeavour to respond to any comments or requests for further information. Lastly, he suggested that consideration should be given to reconvening, under the possible joint sponsorship of several bodies, including the Committee on Economic, Social and Cultural Rights and WHO, of the workshop on the right to health as a human right, previously convened at The Hague in July 1978; to reconvene that forum would be timely, given the enormous changes that had taken place since then.

The meeting rose at 12.55 p.m.